STATE OF CONNECTICUT

OFFICE OF THE CHILD ADVOCATE

IN CONSULTATION WITH THE STATE CHILD FATALITY REVIEW PANEL

CHILD FATALITY INVESTIGATIVE REPORT

LONDYN S.

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INTRODUCTION

On October 19, 2014 at approximately 9:05am, Londyn's 13 year-old sister called 911 requesting an ambulance. She indicated that her 2 year-old sister was not breathing. When police and emergency personnel arrived at the family home, Londyn was transported to a community hospital. She was pronounced dead at 9:30am. Due to her untimely death, the Office of the Chief Medical Examiner (OCME) did an investigation, including a full autopsy, and on March 11, 2015 made a finding of homicide due to Suboxone toxicity. Suboxone is a drug used to treat adults who are addicted to or dependent on opioid drugs. On April 15, 2015, the State Child Fatality Review Panel voted unanimously to direct the Office of the Child Advocate to investigate and issue a report regarding the circumstances surrounding the death of Londyn S.[1] This report follows.

The death of any child is the most profound loss to family, friends, and communities. The Office of the Child Advocate, in consultation with the state's Child Fatality Review Panel, submits this investigative report with the utmost respect to Londyn's family and those that cared for and mourn her. A review of child fatalities is essential for the state to understand how to support children and families and prevent future tragedies. Infants and toddlers such as Londyn are most at risk for sudden and untimely death. They are completely dependent on a competent adult caretaker and they are the most vulnerable and least visible children in our community. Both here in Connecticut and around the country, the overwhelming majority of deaths due to abuse or neglect are children younger than four years old.[2]

The Office of the Child Advocate (OCA) is an independent state oversight agency directed by law to investigate and report on the efficacy of child-serving systems and to investigate unexplained and unexpected child fatalities. The Office of the Child Advocate is a permanent member and current co-chair of the State Child Fatality Review Panel. The OCA was created in 1995 in response to the death of an infant involved with the Department of Children and Families. [3]

The State Child Fatality Review Panel (CFRP) is staffed by OCA and is charged by law with reviewing all unexpected and untimely deaths of children. The purpose of the review is outlined in Connecticut law: "[the] development of prevention strategies to address identified trends and patterns of risk and

[1] The CFRP may "upon request of two-thirds of the members of the panel [direct the Child Advocate] … [to] conduct an in-depth investigation and review and issue a report with recommendations of the death or critical incident of a child. The report shall be submitted to the Governor, the General Assembly and to the commissioner of any state agency cited in the report and shall be made available to the general public."

[2] Nationally, "four-fifths (82%) of children who died from *maltreatment* [as opposed to accidental or other preventable manners of death] were under the age of 4 years; 42% were younger than 12 months." CHILD WELFARE LEAGUE OF AMERICA, QUALITY IMPROVEMENT REPORT 32 (2014).

[3] OCA was initially established after the tragic homicide of a baby with an open child welfare case. Subsequently, child death review has become an integral component of the OCA-enabling statute and a particular focus of the work of the Office. OCA has regularly monitored and reported on child deaths in Connecticut and has prepared and published numerous child death investigative reports for the purpose of informing the public regarding the causes of preventable child death and strategies for prevention.

to improve coordination of services for children and families in the state."[4] The CFRP is comprised of individual appointees representing various disciplines: law enforcement, neonatology, pediatric medicine, emergency pediatrics, child welfare, family violence, legal, public health, and mental health.

This report contains the following information:

Brief Summary

Section I Examines the circumstances leading up to the death of Londyn S.

Section II Recommendations

A. Provides recommendations specific to systems issues identified in connection with this child-specific investigation.

B. Research recommendations regarding the state's two-track Differential Response System

Appendix A Explanatory Note on Child Protection Services and Differential Response System

Appendix B Outline of 2014 Infant-toddler Homicides in Connecticut

Appendix C Structured Decision Making Safety and Risk Assessment Tools

BRIEF SUMMARY OF CASE

Between 2007 and 2014, Londyn's family and her primary caregiver/s were the subject of multiple child welfare reports in both Connecticut and North Carolina that alleged abuse or neglect of children in the home.[5] After the family moved back to Connecticut in 2013, new concerns were reported to DCF when Londyn's baby brother was born. However, Connecticut DCF did not request the the family's North Carolina child welfare records until after Londyn died in October, 2014.[6] In 2013 and 2014, DCF assigned the family to its new Family Assessment Response (FAR) track developed to assess and engage families considered at lower risk of child maltreatment. Concerns regarding the primary caregiver's history of mental health and substance abuse treatment needs, as well as the pattern of chronic child welfare complaints, were not adequately identified and the corresponding risks to the children in the home were not appropriately addressed.

Documented allegations of suspected abuse and neglect over a period of 7 years (2007 through 2014) included the following concerns:

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[4] CONN. GEN. STAT. § 46a-13l *et seq.* (2012).

[5] The mother's family also had involvement with DCF when she was a child.

[6] DCF Policy 34-5 states that "If the parent or person responsible recently resided in another state, the investigator shall contact that state's child protective services authorities to obtain information regarding the family's contact with that agency." It is important to note that this policy was not followed in two of the child fatality cases that occurred in 2014.

Date	Referral	State*	Age of Londyn	Reported Concerns	Services Delivered
July 2007	1st	CT DCF	Not born	Physical abuse of 3 year old.	Accepted for investigation. Unsubstantiated; case closed. No services offered.
February 2008	2nd	CT DCF	Not born	7 year old missed 20 days of school.	Accepted for investigation. Educational neglect substantiated; case closed. No services offered.
May 2011	3rd	NC DCF	Not born	Physical neglect; substance abuse.	None documented.
April 2012	4th	NC DCF	1 month old	Substance abuse; neglect; deplorable home conditions.	None documented.
August 2012	5th	NC DCF	5 months old	Overdose death in the home; substance abuse allegations.	None documented. Family soon moved back to CT.
January 2013	6th	CT DCF	9 months old	Mental health concerns; recent suicide attempt by mother during pregnancy.	Accepted for Family Assessment (FAR); Referral to community partner agency (CPA)[7]: Services offered: counseling, child care, housing.
September 2013	7th	CT DCF	17 months old	Domestic violence by father of older children (did not take place in Londyn's home).	Accepted for investigation; substantiated and closed under father's case; children still involved with CPA.

[7] When a family is assigned to the Family Assessment Response track, the assessment by DCF will *not* result in a legal substantiation of abuse or neglect unless it is reassigned to the Investigations track.

January 2014	8th	CT DCF	21 months old	Londyn in snow wearing a diaper, t-shirt; physical neglect. Unsubstantiated.	Accepted. Investigated. Closed.
August 2014	9th	CT DCF	28 months old	Mother shoplifting.	Accepted for Family Assessment. Referred again to CPA;community supports for family.
September 2014	10th	CT DCF	29 months old	Police call: anonymous complaint to police regarding physical abuse of youngest children. Police visited home; bruises on Londyn's face; family denies abuse, provides explanation.	Not accepted for formal investigation by DCF. Record of call instead forwarded to local DCF staff already working with the family.
October 2014	11th	CT DCF	30 months old	Police call: Londyn's death.	Surviving children placed into protective custody by DCF.

Londyn's family returned from North Carolina in 2012 shortly after the death of an adult in the family home. In 2013 Londyn's mother was again reported to Connecticut DCF upon the birth of her youngest child due to the health care provider's concerns about mother's history of suicidality and significant mental health treatment needs. The family was twice assigned by DCF for a Family Assessment Response (hereinafter "FAR") in 2013 and 2014. Since 2012 DCF has operated a two-track framework for responding to suspected child abuse or neglect called Differential Response. This framework permits DCF to assign lower-risk families to an alternative track that may, after the DCF assessment, connect families with a DCF-contracted provider for community-based case management and services. In Connecticut this lower risk track is called Family Assessment Response (see Appendix A for explanation of terms). Higher risk concerns, such as reports alleging physical or sexual abuse, are tracked to traditional DCF investigations for a possible child protective services response. Families on both the tracks are assessed for risk and safety concerns by DCF prior to the disposition of the case. Since 2012, over 40% of all calls of suspected child abuse or neglect to the DCF hotline have been assigned to the FAR track.

Authors of this report conclude that Londyn's family was inappropriately assigned by DCF to its lower risk FAR track in 2013 and 2014, facilitated by inadequate assessments of the needs and risks presented by the caregiver and the impact on the safety and well-being of the four children in the home. An internal review by DCF reached the same conclusion. Though some or all of the children in the home were the subject of reports to DCF on *five occasions* between January 2013 and Londyn's death in

October, 2014, repeat assessments of the family by DCF failed to include material information about the parent/s' mental health treatment needs, substance abuse history, child welfare history, and the impact of these challenges on the children in the home. Londyn's biological father was not interviewed by DCF until after Londyn died, though attempts were made to contact him. Compounding the deficiencies in case practice and assessment, a report from the police to DCF only weeks prior to Londyn's death alleging possible child abuse of Londyn and her baby brother was not accepted by DCF for formal investigation and instead was addressed by the family assessment team at the final meeting with the family before case closure. Authors find that a new report of possible child abuse of a toddler should have changed the track of this case from Family Assessment to Investigations. Lastly, the case plans developed with the family by DCF and the FAR-track Community Partner Agency did not reflect the extensive clinical needs in the family and did not provide sufficient support or supervision to ensure safe parenting and a safe environment for the children.

Authors' recommendations focus on the need for DCF to implement a robust quality assurance framework to support effective safety and risk assessment practices for families and ensure that the needs and risks facing children, particularly infants and toddlers at greatest risk of critical or fatal injury, are thoroughly identified and addressed. Efforts to preserve families through a one-track or two-track child welfare response system may be appropriate, but these efforts can only be successful with reliable safety assessment (i.e. how well does the agency identify which children are at "high" risk and which are at "low risk) as well as effective service delivery and supervision. Child welfare and DCF-contracted case practice activities and outcomes for children must be rigorously measured and publicly reported. DCF must also have needed resources to provide the necessary social work support and supervision for abused and neglected children remaining in the home. Authors include a separate section consisting of recommendations for further evaluation of the state's two-track system for responding to allegations of abuse or neglect.

DCF is currently taking several steps to examine and improve the consistency and reliability of its risk and safety assessments as well as its case practice with young children and their families and these efforts are outlined in the Recommendations Section of this report. Moving ahead, DCF, its community partners and sister state agencies (Office of Early Childhood and Department of Social Services, e.g.) must endeavor to expand capacity within the continuum of services for young children at risk of maltreatment, with priority funding for intensive, trauma-informed services that will work with the parent *and* child in the home and other settings.[8] National experts consistently articulate the "collective responsibility and accountability for preventing fatalities," and "two-generation funding

[8] The Connecticut Children's Behavioral Health Plan issued by the Department of Children and Families in 2014 specifically recommends expanding services for families that have very young children. The report cites a "convincing body of evidence that home visitation programs improve developmental outcomes, increase caregiver capacity, reduce incidents of abuse and neglect…. A two-generation, trauma-informed, developmentally appropriate approach that focuses on the relationship between caregiver and child is fundamental to protecting the developing brain from the devastating effects of stress and trauma and is the foundation for interventions with this population…. The state's service capacity to offer preventative interventions is inadequate, with long waitlists for some evidence-based interventions." Report at 34.

strategies to support families and help to break the intergenerational cycle of abuse."[9] The human, emotional and financial cost of child maltreatment is extraordinary compared with the cost of life-saving prevention.[10]

METHODOLOGY

- Review of documents from the Office of the Chief Medical Examiner;
- Review of DCF case management and activity records— the DCF online management system of records related to investigation, ongoing case work activity, supervision, risk assessment, and treatment planning;
- Review of the DCF Internal Special Review Fatality Report on Londyn and her family;
- Review of community provider reports, including police reports;
- Multiple interviews with individuals knowledgeable about the systems or services provided to Londyn's family;
- Consultation with the Child Fatality Review Panel;
- Meetings and discussions with DCF personnel;
- Review of data regarding Family Assessment Response provided by DCF in partnership with University of Connecticut School of Social Work.
- Literature review on the topics of risk and safety assessment; fatality prevention; Differential Response Systems (DRS); Structured Decision Making (SDM) and child welfare quality assurance systems.

Section I: Londyn's Family History with DCF

At the time of her death, Londyn—age 2—had two older siblings a (sister age 13 and a brother age 10) as well as a younger brother (21 months of age). Londyn's father resides in North Carolina.

July 3, 2007 (Call # 1 - CT DCF)

A medical clinic staffperson called the DCF Careline (then called the "hotline") to report that mother was in a parking lot kicking her 3 year-old son (Londyn's older brother) in the back and slapping him in the face. Inside the clinic, caller alleged that mother stated she was going to kill the child when she got home. DCF investigated the case and determined that the allegations would not be substantiated. Case records indicate that no services were offered and the case was closed at the investigation level.

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[9] Presidential Commission to Eliminate Child Abuse and Neglect Fatalities, "*Not One more Death from Child Abuse and Neglect: A 21st Century Strategy for Protecting our Kids" [DRAFT],* found…

[10] A recent study by the Center for Disease Control entitled *The Economic Burden of Child Maltreatment in the United States and Implications for Prevention* found that a death to child maltreatment "had a lifetime cost of about $1.3 million," and the "[t]he lifetime cost for each victim of child maltreatment who lived was 210,012 which is comparable to other costly health conditions such as stroke … or type 2 diabetes." Link to the study found on the web here: http://www.cdc.gov/violenceprevention/childmaltreatment/economiccost.html (last checked, Dec. 1, 2015).

When the initial Structured Decision Making (SDM) Safety Assessment was completed[11] the children were determined to be Safe, and the SDM Risk Assessment tool determined the family's risk to be Very Low.[12]

February 7, 2008 (Call # 2 - CT DCF)

An anonymous caller reported to the Careline that a 7 year old child in the home (Londyn's older sister) had already missed twenty days of school. The DCF investigation substantiated educational neglect against both parents. No services were offered and the case was closed. The SDM Initial Safety Assessment was determined to be Safe and the overall SDM Risk Assessment was Low.

Family moves to North Carolina.

Londyn is born in North Carolina on March 17, 2012

After Londyn died, Connecticut DCF requested records from North Carolina Child Protective Services regarding the family's child welfare history in that state. Connecticut DCF received the records on October 27, 2014. These records provide the following information:

There were three child protection reports on Londyn's family in North Carolina.

1. The first report was in May 2011 (Londyn was not born yet). The allegations were that the children "are very unkempt; they look dirty and neglected." Allegations were that the house was falling apart, the parents had not been seen for a few weeks and a teenager appeared to be in charge. There were reported concerns of substance abuse in the home: caller referred to the parents as "addicts." The allegations were not substantiated after review by North Carolina Child Protective Services (CPS). There is no indication that any services were offered to the family.

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[11] The SDM Safety Assessment lists multiple questions such as whether the caregiver "caused serious physical harm to the child," or "fails to protect child from serious harm." Other questions listed include "caregiver does not meet the child's immediate needs for supervision, food clothing and/or medical or mental health care; caregiver's current substance abuse seriously impairs his/her ability to supervise, protect, or care for the child; caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs their current ability to supervise, protect, or care for the child; there is a pattern of prior investigations or behavior AND current circumstnaces are near the threshold for any other safty factor." If the SDM Safety tool reveals the presence of *any* safety factors, DCF will determine whether there are any interventions that will allow the child/ren to remain in the home or if the child/ren need to be taken into protective custody. A copy of the SDM Safety and Risk tools are contained in Appendix C.

[12] The SDM Risk Assessment tool (which may *impact* safety of children) also asks a series of questions, including whether the family has prior [DCF] investigations, whether the household has children under the age of 2, whether the "primary caregiver has a past or current mental health problem," whether the "primary caregiver has historic or current alcohol or drug problem." A family's risk can be assessed as "very low," "low," "moderate," or "high." Families that score "very low" or "low" are the most likely to be assigned to the alternative FAR track by DCF. Families that score High or the most likely to remain with DCF for Child Protective Services investigation and supervision. Families that score moderate may be assigned to either track. Please see Appendix A and C for more detail.

2. The second report to child welfare authorities was in April 2012. The report came from police and alleged that the home was "a sort of halfway house for potheads," the house was filthy, filled with animals, urine smell, and trash everywhere inside and out, and the house had "a worse appearance than a crack house." The police officer stated that while he observed mother feeding her new baby, police did not observe baby supplies. The case was not substantiated; however it appears to have been kept open when a 3rd call was received.

3. The third report was in August 2012 following the death of Londyn's step-grandfather in the home, allegedly from a drug overdose. He had just been released from jail and he died the following day. After his death, Londyn's family moved back to Connecticut in August 2012.

January 23, 2013 (Call # 6 - CT DCF)

Five months after the family's return to Connecticut, the DCF Careline received a call from a community hospital reporting concerns for mother's mental health. The reporter indicated mother was feeling overwhelmed and considering adoption after giving birth to her fourth child, born less than a year after Londyn's birth. The reporter noted that Londyn's mother presented with a history of self-injury and diagnoses of Anxiety, Depression, and Borderline Personality Disorder. Mother also had attempted suicide on multiple occasions, including during this pregnancy and she reported a history of Post-Partum Depression. The hospital reported it had referred mother for mental health treatment during her pregnancy but she did not follow through with this recommendation. The hospital had begun an adoption process at the mother's request but she later changed her mind and decided to keep the baby. Ages of children in the home were 12, 8, 1 (Londyn), and the newborn baby boy.[13]

DCF accepted the report and and assigned the family to the FAR track. At this time Londyn's mother reported to the DCF FAR assessment team her history of depression, which she estimated began at age 12 or 13. She also reported that she attempted suicide on multiple occasions, the most recent attempt taking place seven months earlier when she discovered she was pregnant again shortly after Londyn's birth. Londyn's mother reported to DCF that she was agreeable to taking medication but that she did "not feel the need for individual therapy."[14] DCF noted that mother's past history presented a concern that as she becomes more depressed, she becomes unable to cope. Case notes indicated that DCF planned to follow up with the mother's outpatient mental health provider to verify what the recommendations were, but the record contains no documentation regarding whether these records were obtained or reviewed.[15] Note that the Family Assessment Response Practice Guide created by DCF states that part of the process of determining the appropriate "track" for a family will be not only consideration of safety and risk factors, but also "the family's willingness to address or

[13] DCF Case Record and Careline report, January through March, 2013.
[14] DCF Case record, March 2013.
[15] Case record notes indicate that certain mental health records were requested.

mitigate safety or risk concerns."[16] Because the primary concern brought to DCF's attention was the mother's mental health treatment needs, the issue of what those needs were and whether the mother was amenable to treatment were material to the assessment process.

The SDM Safety Assessment was scored as Safe and the Risk Assessment was scored as Moderate. No records were requested from North Carolina DCF. As a result, SDM assessment questions regarding whether the parent has "historic or current alcohol or drug problem" were determined to be "not applicable, " and the question regarding the number of "prior [DCF] investigations" was scored as "one or two" and not "five."

FAR Service Plan

DCF concluded its assessment in March, 2013 and referred the family to the DCF-contracted Community Partner Agency (the FAR provider), identifying the following service needs for the family:

- Counseling for Londyn's mother;
- Access to child care;
- Identification of summer camps for older children;
- Assistance with housing.

Per DCF policy, with the commencement of the FAR service plan by the Community Partner Agency (CPA), DCF closed its child protection case.

In June 2013, with the help of the Community Partner Agency, an application was submitted and approved for subsidized childcare. Connections were also made to local non-profit groups that assisted the family in securing clothing and baby supplies. A housing deposit was secured. Referrals were made for mental health services for mother and the oldest child.

In October 2013, the Community Partner Agency made a referral for the family to the state's Birth to Three system for a developmental evaluation of Londyn. Subsequent to Londyn's death, OCA reviewers determined that the Birth to Three provider made multiple attempts to contact Londyn's mother without success and closed the referral on November 6, 2013.

The CPA wrote that staff "repeatedly tried to encourage [mother] to engage in mental health services based on the information given at time of referral and based on the stress level [mother] appeared to be experiencing…".[17]

Londyn's family was discharged from the Community Partner Agency on November 7, 2013; the case had been opened for 8 months (twice the duration of a typical FAR intervention).[18] Discharge

[16] DCF Family Assessment Response Practice Guide, at 8.

[17] Eventually the mother did begin services at a local counseling center. However, by the Fall of 2014 the counseling center had discharged the mother for non-compliance.

[18] Recent reports on FAR created by DCF in partnership with the UConn School of Social Work, dated August 28, 2015, report that the average duration of services is 4 months. OCA's interview with the

summary notes from the CPA indicated that Londyn's mother attended 1 of 1 initial assessments with the CPA, but that she missed *almost half* of her case management appointments (9 of 20). Currently, the extent of family engagement or lack thereof does not necessarily require a report back to DCF.

September 1, 2013 (Call # 7 - CT DCF)

The Naugatuck police department called the DCF Careline to report a family violence incident between the father of Londyn's older siblings and the father's girlfriend. The report indicated that Londyn's 12-year-old sister tried to separate the adults. The investigation concluded that the allegation of physical and emotional neglect of the children was substantiated against the father. The 12-year-old girl reportedly told the police (documented as well in the DCF case record) "if you think my father is messed up you should see my mother." The SDM Initial Safety Assessment was determined as Safe and the SDM Risk Assessment was Moderate. The case was closed by DCF following the substantiation finding. The mother and children were still involved with the Community Partner Agency at this time.

January 20, 2014 (Call # 8 - CT DCF)

Two months after Londyn's family's case was closed by the Community Partner Agency, a driver on Route 6 called the police to report that a child (then 22 month-old Londyn) was on the side of the road crouched in the snow wearing just a diaper and T-shirt. The police called the DCF Careline to report that Londyn's 13-year-old sister and her 19-year-old uncle were in the home (the 13 year old was tasked with watching Londyn). Londyn's mother was in Bristol buying a coat she found on Facebook. The case was accepted by the Careline and referred to the local DCF office for an investigation.

The DCF investigation documented that records were sought by DCF from the children's medical providers and schools. DCF records indicate that by this time both Londyn and her younger brother had been referred to the Birth to Three System by their pediatrician and the CPA that worked with the family in 2013. Records indicate that these referrals were not followed up by the mother. The pediatrician reported that Londyn's younger brother missed his 18-month well child check. Educational records documented concerns about Londyn's 10-year-old brother as follows: "He has complained that no one at home listens to him, and he gets teased at home."

The allegation of physical neglect was *not* substantiated and DCF closed the case at the investigation level; no services were noted. The SDM Initial Safety Assessment was determined to be Safe and the SDM Risk Assessment was Moderate.

August 22, 2014 (Call # 9 - CT DCF)

Seven months later, police again called the DCF Careline due to the arrest of Londyn's mother for shoplifting. The report indicated that there was another shoplifting charge against Londyn's mother a

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Community Provider Agency for Londyn's family also confirmed that, from the perspective of the community agency, the average duration of service for a family in the FAR program is 4 months.

few weeks earlier.[19] The family's case was again assigned to the FAR track. DCF made a referral to the same Community Partner Agency that had worked with the family in 2013.

During the referral process the local DCF office sought information from the child's dentist, pediatrician, and schools and from the mother's previous mental health treatment provider. ***There is no indication in the case record that any of these entities responded to the request for information by DCF at this time.*** Again, no records were sought from the North Carolina child welfare agency.

Records do not reflect that this second FAR assessment by DCF included a determination as to the quality or success of the first FAR intervention in 2013.

In the referral forms submitted by DCF to the Community Partner Agency, DCF provided the following information:

- A list of household members (mother and four children);
- A summary of "presenting issues / concerns" and "relevant history" with DCF including a brief outline of the 2007 unsubstantiated case of physical abuse, the 2008 substantiated case of educational neglect, the January 2013 case (at the time of the youngest child's birth), the September 2013 substantiated case of physical and emotional neglect due to a domestic violence incident between the older children's father and his girlfriend.
- Brief information regarding Londyn's mother's most recent arrests for shoplifting and risk of injury charges in July and August of 2014.

The CPA's Service Plan also noted the following:

"Mother would like assistance in connecting to community agencies to assist her with energy assistance, food, clothing banks, and any other community providers who could provide support to her family." Londyn's mother added a hand written request: "assist in childcare."

On September 17, 2014, the CPA completed its intake and DCF readied its child welfare case for closure. However, Londyn's mother missed the next two appointments on 9/23 and 9/26, which DCF learned of prior to completing the closing summary on October 6. The SDM Initial Safety Assessment conducted by DCF was determined to be Safe and the overall SDM Risk Assessment was Moderate.

September 28, 2014 (Call # 10 - CT DCF)

Call to the DCF Careline by the Plymouth Police Department reported that police had received an anonymous call from a friend of Londyn's mother asserting concern for the physical safety of Londyn and other children in the home. The anonymous caller reported to police that mother stated "*I beat the shit out of them; I don't know what I did to them*" referring to her two youngest children (Londyn and her 1 year-old brother). Police reported to DCF that an officer conducted a child well-being check

[19] On July 15, 2014 Londyn's mother was arrested for shoplifting, and was also charged with risk of injury to a minor as the children were present during the shoplifting. There was no call to the DCF Careline regarding this incident.

and saw bruises on Londyn's face as she slept. Police reported that the family, including Londyn's siblings, denied abuse and claimed that the child is rambunctious and had fallen.

The DCF Careline did not accept the call for further investigation and DCF was unable to locate the recording of the call upon request.[20] Because the allegation was not accepted for investigation, DCF did not request or facilitate an examination of the child by a medical provider to corroborate the mother's history for the mechanism of the bruises or look for other signs of abuse, and DCF did not seek to identify or interview the person who made the abuse allegations to police.

The written record regarding the call is no longer in DCF's database as agency practice at that time dictated that "non-accepts" were removed from the database within 60 days.[21]

Despite the decision not to investigate the allegation of abuse, DCF case workers and the Community Partner Agency did visit the family home on October 2, four days after the Careline call by police. The allegation of physical abuse of Londyn and her younger brother was discussed during this meeting. At that time the DCF case worker noted the home "to be adequately clean with some clutter but no noted safety issues or concerns."[22]

DCF records noted that the new allegation of physical abuse was not enough to "change the track" from the low risk FAR program back to the child protective services track. DCF closed the case on October 6, 2014.[23]

Police Report, September, 28, 2015

According to the police report sent to DCF, complainant had seen mother "drag her infant children around by the arms; [and stated that mother] also smacks them in the face to get them away from her…[complainant] told police that [mother] told her 'I f---ing beat the shit outta them. I don't know what I did to them.' [Complainant] saw a bruise on Londyn's left eye and a cut above and below the same eye, also saw an old bruise on the top of [baby's] ear…. [Complainant] stated that 'the fact that she is alone with these kids is making me sick.' She told police that [mother] is not right in the head, may be having a nervous breakdown and does not appear to want her kids anymore…. [Complainant] went over there today because she was worried about [mother] because she is depressed."

[20] Per DCF practice, calls to the DCF Careline are typically maintained and available for review.
[21] According to a recently published DCF Action Plan regarding the Connecticut Juvenile Training School, DCF has implemented a practice change to maintain non-accepts in the DCF database for up to 2 years.
[22] Family Assessment Protocol, pg. 7.
[23] During a June 24, 2015 meeting between OCA and DCF regarding the Careline, DCF administrators stated that the Careline report from police was properly not-accepted for investigation as it consisted of third-hand information and the police officer was not specifically reporting his *own* suspicion of abuse or neglect. In correspondence dated October 19, 2015, DCF administrators stated to OCA that the decision not to accept this new allegation for another investigation was not a mistake as DCF "knew virtually all of the information that would be gathered during the investigation" and DCF personnel asked the mother for her explanation. DCF also stated to OCA that a new "allegation" alone is "never enough to make a significant case direction to change. The allegation must be proven."

The police officer conducted a well-child visit at the home, and met with the two older children (ages 10 and 13) individually. The younger child told the police that his mother "does get upset at his younger brother and sister and does smack them on the butt and hand, [but not on the face or head]." The boy also said that London falls a lot, and once fell off a chair. The older girl acknowledged that mother does spank the younger children "on the butt to make them listen," but that mother never hit her when she was a child. The officer observed Londyn while she was sleeping and saw a "Faint black and blue mark around the corner of her left eye and a red mark above and below her left eye." The police officer spoke to mother about any challenges she may be facing and asked her if she needed some help. The police officer advised mother that DCF would be contacted. The family denied that Londyn had been hit and stated that she had fallen.

The Police report was submitted to DCF within 72 hours of the officer's call. It was subsequently filed in Londyn's DCF case record.

October 6, 2014—DCF Closed Londyn's family's case.

The DCF case summary in October, 2014 noted that "mother is currently receiving services through Bristol Counseling Center for her mental health needs." However, the mother had reported to the case worker that she was not actually receiving services due to a lapse in her insurance, and by this time the mother, unreported to DCF, had already been discharged from the provider for lack of attendance.

The case record indicated that "the children report to liking school and to doing well…. No issues or concerns noted." However, the record indicated that no updated educational records (or attendance records) were obtained prior to case closure. Regarding the mother's substance abuse issues, the summary stated that "mother denied any chemical health issues [and] [t]here are no indicators." Though the summary noted the mother's history with Post-Partum Depression, and her own history with DCF as a child, the case record states that "mother denied a history of past trauma issues that would impact her parenting." And though the worker requested the mother's treatment records, the records were not obtained and did not inform DCF's risk or safety assessment. The SDM Safety Assessment was scored as Safe and the Risk Assessment was scored as Moderate. With the hand-off to the Community Partner Agency, DCF closed its case.

October 19, 2014 (Call # 11 - CT DCF)--Londyn's Death.

Less than two weeks after DCF closed its case, the Plymouth police called the DCF Careline at 4:30 pm to report a 911 call that morning that a child (Londyn) was unresponsive. Police indicated that they had responded to the home and the conditions were "deplorable" and the place was "a sty." Police indicated an investigation was ongoing at the apartment.

After Londyn's Death, DCF investigates conditions in the home.

DCF immediately commenced an investigation into conditions in the home that may have contributed to Londyn's death. The newly assigned DCF case worker collected extensive collateral information from the children's school, doctor, and service providers, as well as information from the mother's medical and mental health treatment providers. At this time DCF also sought the family's child welfare record from North Carolina and interviewed Londyn's biological father who was living in North Carolina at the time of Londyn's death.

The DCF investigator made the following findings:

1. The mother had been attending a local counseling center through the Spring of 2014, but had been discharged by September due to "lack of compliance with engagement."[24] No report was made by the mental health provider to DCF regarding mother's unsuccessful discharge from treatment and the potential impact on her children.
2. Mother's insurance had been lapsed for months but the mother had not taken steps to re-instate her benefits.
3. The children were not all medically up-to-date with [well child checks] and immunizations.[25]
4. One of the children reported that "there is nothing severe but mother smacks them sometimes 'as a normal parent would.' [The child] denied any stressors or anxiety but stated more than once that 'he becomes paranoid.'[26]
5. Mother did not regularly bring one of her children to counseling as recommended and did not complete paperwork to have her other child evaluated as recommended by the pediatrician.
6. Mother's mental health records indicated she was diagnosed with Bipolar Disorder, Depressed type, and that her urine continued to test positive for marijuana through June of 2014. Records confirmed her multi-year history of opiate use, self-injury and suicidal ideation.[27] Mother complained of "anger, losing track of time, lack of focus, fluctuating moods."[28] She reported that her own mother had substance abuse problems and "had been in and out of mental hospitals."[29] Mother was diagnosed with opiate use disorder, cannabis abuse disorder, (possible recent remission) Borderline Personality Disorder with recommendations for individual and group therapy.[30]
7. Mother's medical records for the previous year revealed multiple complaints of back pain and tooth pain and resulting prescriptions for pain killers such as Vicodin, Percocet and Oxycodone. By spring of 2014 mother reported to her provider increased depression and anxiety and complained "that it was becoming very difficult for her to function in her activities of daily living." The health care provider noted that mother "did not want to wait for a crisis evaluation."[31] No report to DCF was made by the medical care provider.

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[24] DCF Investigation Protocol, pg. 13.
[25] Id. pg. 15.
[26] Id. pg. 17.
[27] Id. pg. 21.
[28] Id.
[29] Id.
[30] Id.
[31] Id. pg. 25 referencing mother's medical records.

8. Mother disclosed to police after Londyn's death that she was taking multiple psychotropic drugs, had smoked marijuana, took opiates through medication prescribed to other people, and illegally traded for Suboxone when she was sick from not having opiates. Mother claimed to have stopped using opiates "cold turkey," but could not provide a date for her last use. She described a history of difficult withdrawal symptoms.
9. In November, following Londyn's death, mother tested positive for opiates and marijuana.[32]
10. In the interview with Londyn's father, DCF learned that several adults in the North Carolina household, including mother, had allegedly abused drugs, including multiple opiates.
11. DCF concluded that mother had an extensive trauma history, including growing up with a substance-abusing parent and exposure to domestic violence.[33]
12. The DCF investigator concluded that "mother was raised in a culture of mental health and substance abuse. She was predisposed to Substance Abuse at a very young age…mother was roughly 12 years old when she was subjected to abuse and neglect as a minor…. Mother is not employed and was so engaged in substance abuse and preoccupied with her mental health that she did not pay attention to maintaining her home and the risk associated with the conditions of her home relative to her children."[34]

Virtually all of the above information was discoverable prior to Londyn's death.

An SDM Safety Assessment on November 14, 2014 determined that conditions were Unsafe and on December 1, 2014 the SDM Risk Assessment was determined to be High. Londyn's siblings were removed from the mother's care. Authors determined that all of the information above, had it been obtained, would have resulted in an SDM Risk Assessment of High and a positive Safety Assessment score prior to Londyn's death.

Chief Medical Examiner Concludes Londyn's Death is a Homicide.

Following Londyn's death, the Office of the Chief Medical Examiner's investigation revealed the presence of *multiple* drugs in Londyn's system, including Suboxone. Mother initially denied any drug use, but later admitted to trading with others to illegally obtain drugs, including Suboxone. Suboxone is a form of medication-assisted treatment used in combination with behavioral health therapy to overcome opiate and opioid abuse or addiction. Its delivery method is in the form of tablets or a sublingual film that readily dissolves under the tongue, similar to a Listerine breath strip. As a result of Londyn's death, Londyn's mother was charged with Manslaughter.

[32] Id. pg. 39.
[33] Case Record, pg. 60.
[34] DCF Investigation Protocol, pg. 35.

FINDINGS

1. **Inadequate Assessment of Risk to Children in Londyn's Home.**

- **DCF did not obtain adequate information regarding the mother's mental health status, substance abuse history or the impact of these issues on the children until after Londyn died.**

  Londyn's mother was the subject of multiple prior DCF reports dating back to 2007 alleging physical abuse, untreated mental health issues, negligent supervision of a young child and educational neglect. During the most recent DCF assessments prior to Londyn's death, DCF either minimized or *did not know* the clinical and substance abuse treatment needs of the mother and therefore could not assess or address the risks to the children in the home.

  Twice DCF assigned the family to the FAR track (for lower risk families) and for case management by the Community Partner Agency without critical and material information about the family's needs.

  Despite the family coming back to DCF's attention three more times prior to Londyn's death, DCF repeatedly did not obtain or review relevant mental health, substance abuse or child welfare records. At various points, certain records were requested by the case worker, but when records were not received no effective steps were taken by the supervisory chain of command or the DCF office's legal staff to obtain the records in a timely fashion.[35] Instead, at the end of its 45 day assessment period, DCF closed the case. This meant that not only did DCF not have the necessary information for its risk and needs assessment, the DCF-contracted provider did not have it either.

  Effective response to child welfare concerns hinges on reliable and thorough assessments. Understanding the risk issues in the home is essential for children's safety and enables the case manager to make good decisions regarding potentially effective interventions that can increase parental capacity and sustain children's safety over time. The entire child welfare response system depends on the accurate and reliable safety and risk assessment of the family, from the Careline to the dispositional determinations. Essential information was available prior to Londyn's death that should have resulted in an SDM risk score of High, thereby triggering a child protective services response and continued supervision of conditions in the home by DCF. The erroneous assessments in this family's case jeopardized the safety of the children in the home.

[35] The FAR Practice Guide provides that, with regard to obtaining information from collateral contacts, the "social worker shall inform the social work supervisor the status of the collateral contacts and develop strategies to gather information that would help inform the assessment." Guide at 12. "If the information … is critical to the assessment, the Social Worker or Supervisor may consult with the Program Manager, Area Office legal staff, or Regional Resource Group to determine next steps." Id.

- **DCF did not seek or obtain out-of-state child protective services records as required by best practices and DCF policy.**

  Compounding the serious errors described above, DCF never sought the out-of-state child welfare records from the family's residence in North Carolina. DCF policy states that such records must be requested when a family subject to a DCF investigation has lived in another jurisdiction. Here, the records were not sought *at any time* prior to Londyn's death, despite the family coming to DCF's attention on at least 4 occasions between 2013 and 2014.

  The North Carolina record underscored the urgency and potential severity of the primary caregiver's mental health needs, history of suicidality and suicidal ideation, and substance abuse treatment needs. The failure to seek or obtain child welfare records from the family's previous state of residence was a significant contributing factor to the deficient risk assessment. Authors of this report conclude that had DCF obtained these records, it would have likely opened a traditional investigation and child protective services case. Such a case could have led to ongoing DCF supervision, possible oversight of the children's safety by the local juvenile court and compelled participation in treatment services

- **DCF did not adequately employ its safety assessment tool: the Structured Decision-Making, or SDM, tool.**

  Connecticut DCF, like other states, utilizes the SDM risk and safety assessment tools to guide decision-making regarding a family in the wake of allegations of abuse or neglect. In this case, DCF's use of the SDM tools led the case worker/s to document a lower level of concern than was warranted by the growing volume of child protective service complaints. The SDM must be supported with comprehensive fact-finding and expert-driven analysis of risk and safety concerns presented by the family and caregivers. It is not enough to respond to the *singular presenting concern* (e.g., exposure of a young child to the elements, shoplifting with children) without reflective consideration of the historical and documented context of parental substance abuse, suicidal ideation, untreated mental health issues and the impact of compromised parental functioning on the safety of young children.[36]

  Londyn's mother had two young children with possible developmental needs and two middle-school age children with emerging mental health needs. She was overwhelmed with financial and subsistence issues. She presented with a lengthy history of significant mental health issues,

[36] Shlonsky, A., Wagner, D., (2005) *The next step: Integrating actuarial risk assessment and clinical judgment into an evidence-based practice framework in CPS case management.* Children and Youth Services Review 27, 409-427, 421. ("A comprehensive, contextualized family assessment is required to identify and clarify relevant problems at the individual, family, community, and societal level. In particular, specific problem behaviors and the context in which they occur must be clearly identified and described. Obtaining information about how the clients view the problem is also key. Client perception may be more accurate and informs case planning in terms of setting and attaining agreed-upon goals. Likewise, individual and family strengths (e.g., social support, employment, strong emotional ties) must be found, acknowledged, and integrated into case plans."

including Borderline Personality Disorder, a history of Post-Partum Depression, a history of self-injury, documented substance abuse, and a suicide attempt during pregnancy. The record of chronic child welfare referrals indicates significant risks associated with diminished parental capacity, poor judgment and decision-making, and a high risk of child maltreatment.

To illustrate, the SDM Safety tool includes the following questions:

1. Caregiver does not meet the child's immediate needs for supervision, food, clothing, and/or medical or mental health care.
2. The physical living conditions are hazardous and immediately threatening to the health and/or safety of the child.
3. Caregiver's substance abuse seriously impairs his/her ability to supervise, protect, or care for the child.
4. Caregiver's emotional stability, developmental status, or cognitive deficiency seriously impairs their current ability to supervise, protect, or care for the child.
5. There is a pattern of prior investigations or behavior AND current circumstances are near the threshold for any other safety factor.

Any of the questions above could have been answered affirmatively during multiple assessment points, thereby requiring additional steps by DCF to protect the children in the home or seek removal from the home if it was the only protective intervention possible.

By design, DCF will not maintain families on the FAR track if documented safety factors are present.[37] Therefore, the reliability of the FAR framework as a response to child maltreatment necessarily relies on the reliability of the DCF risk and safety assessments.[38]

2. DCF should have opened a child protective services investigation following the September 28, 2014 call from police regarding possible physical abuse of Londyn and her baby brother.

When a police officer called the DCF Careline in late September, 2014 regarding possible child abuse in Londyn's home, the allegation was not-accepted for formal investigation. Instead, an email was sent to the local DCF office asking the case worker to follow up with the parent about the allegation. Four days later the case worker and community provider met with the family to review the concerns. Allegations of abuse were denied. No investigation ensued and the family's DCF case continued to be tracked for closure.

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[37] See *Scope of Services, Contract Performance, Budget, Reports and Other Program-Specific Provisions for Community Support for Families*, pg. 2.

[38] Although DCF does offer a more comprehensive "Family Strengths and Needs Assessment," per agency policy the FSNA is not administered until *after* an investigation is completed and a family is referred for ongoing treatment and DCF supervision. In Londyn's family's case, despite the family's multiple encounters with the Department, this broad assessment was not completed until after Londyn died—because this was the first time that the family's case was opened for ongoing treatment with DCF supervision.

A call of suspected physical abuse, particularly involving a very young child, must *be screened in* by the DCF hotline. Bruising on the head, neck and ear area of a child, as reported by the complainant to police, can be a marker of physical abuse and should prompt a medical evaluation to distinguish accidental from abusive bruising.[39] In addition, recent research confirms that an allegation of abuse regarding a child younger than 5 "signal[s] a significantly greater risk of fatal injury, particularly intentional injury, than does an allegation of neglect or other maltreatment." This research finding, contained in a published study in the Journal of Child Maltreatment (2011) found that children with a prior allegation of physical maltreatment died from intentional injuries at a rate that was *5.9 times greater than unreported children* and died from unintentional injuries at twice the rate of unreported children.[40] Study authors concluded that a "*prior allegation to [Child Protective Services] proved to be the strongest independent risk factor for injury mortality before the age of five.*"[41] (Emphasis added).

In light of these substantial risks and the history of the caregiver with DCF, reviewers find that the agency's decision to not investigate the September 28, 2014 police call regarding possible physical abuse of Londyn was a significant missed opportunity to more fully assess conditions in the home and put child welfare supervision into place for this family. A call from a mandated reporter such as a police officer alleging both a graphic complaint to police about child abuse, maternal depression, and the officer's own observation of facial bruising on a young child (as well as the police report reference to bruising on *both* young children), particularly in a family with a long history of child welfare involvement, should have brought the case from the low-risk track of FAR back to the DCF office for further review and child protective services supervision.[42]

If the case had been accepted for investigation it could have been coded as a "same day" response, the investigator may have been able to visualize the bruises on both children, may have been able to interview the older children individually at that time, and may have requested or otherwise obtained an examination of the children (or a consultation with a Child Abuse Pediatrician) by a medical provider to assess the history or mechanism of bruises and look for other warning signs of abuse. DCF may also have interviewed the complainant to police and obtained more first-hand information regarding the concerns in the home. DCF may have conducted an internal legal consult which could have led to the filing of a neglect petition in juvenile court and more formal and rigorous supervision of conditions in the home.

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[39] http://pediatrics.aappublications.org/content/125/1/67.

[40] Putnam-Hornstein, et al. (June 2011), "Report of Maltreatment as a Risk Factor for Injury Death: A Prospective Birth Cohort Study," Journal of Child Maltreatment, 16, 3 (pp. 163-174).

[41] Id.

[42] A recent article in the American Journal of Public Health found that "children with a previous referral of physical abuse were fatally injured at rates significantly higher than those of children referred for neglect or other forms of maltreatment." Am J Public Health. 2013;103:e39–e44. doi:10.2105/AJPH.2013.301516; see also DCF Family Assessment Response Practice Guide at 7, "[DCF] may modify the type of response from FAR to an investigations response … when a new CPS report is *accepted and designated as an investigation by the Careline*." (Emphasis added.)

3. **Londyn's Family Inappropriately Assigned to the FAR track on Two Occasions.**

Because of the underassessment of risk and safety concerns in the children's home, Londyn's family was twice assigned by DCF to the alternative FAR track intended for families that present with lower risk neglect concerns. The 45-day DCF assessment period following the FAR assignment could have but did not reveal the extensive mental health and substance abuse needs afflicting the children's mother and the persistent child protective services history. All of this information was uncovered by DCF subsequent to the child's death. The presence of safety concerns requires that a family not be assigned to FAR.

4. **Community Service Plan for Family Not Adequate to Address Caregiver Needs and and Children's Safety**

The two case plans developed by DCF and the Community Partner Agency (with input and direction from the children's mother) in 2013 and 2014 emphasized the mother's need for basic assistance with child care, housing and financial support. Though both plans sought to enroll the mother in out-patient mental health treatment, the case plans did not include referrals for intensive trauma-informed clinical and family interventions that were needed. The case plans did not include clear interventions to support the parent-child relationship, despite the mother's history of fear and ambivalence over parenting, her suicidal despair during her last pregnancy and her recent history of Post-Partum Depression. An appropriate case plan would also have common goals coordinated amongst the providers and a methodology for assessing the parent's engagement and progress with such treatment.

Struggling parents should receive help ensuring their children's basic needs for health care, housing and child care are met. However, the emphasis on meeting subsistence needs cannot overshadow or take the place of the need for effective therapeutic supports, particularly when outstanding clinical and substance abuse treatment needs place young children at risk.

It is also not clear that the Community Partner Agency conducted its own risk or safety assessment (nor do FAR protocols clearly require them to do so).

5. **Poor Information Sharing by Community Providers and a Failure to Report Child Welfare Concerns to DCF**

During the DCF assessment immediately prior to Londyn's death the case worker requested the mother's mental health records and did not receive them. The assessment concluded without this information. During the course of this investigation, DCF reported to OCA that it frequently struggles to obtain relevant collateral information in a timely fashion and does not always have the information it needs at the close of the 45-day assessment period.

It is critical that providers have an effective system for responding to requests for information from the child welfare agency and a response time that is reasonably paced. DCF must also have a data-driven system for identifying the most significant barriers to receipt of information

so that it can address these obstacles in an efficient way with local providers. In any event, DCF cannot make critical assessment and dispositional determinations without vital information about parental functioning and the impact on the safety and well-being of children in the home.

Additionally, it is not clear that there is a well-delineated mechanism within the current FAR framework that allows the Community Partner Agency to convey concerns to DCF when a family struggles to engage with them. Londyn's mother missed almost half (9 out of 20) of her appointments during the first FAR intervention. While it may well be that the voluntary nature of the program means that a lack of engagement is considered a non-reportable event, there is nevertheless a growing body of evidence that such non-compliance for families with young children should be managed differently. The FAR intervention is a *response* to a documented concern of child maltreatment and therefore the volitional nature of the intervention must be viewed in that context. At the very least, a collaborative case conference with key stakeholders should be convened to share information and ascertain a fuller picture of the family. The lack of a structured feedback loop with DCF and case conferencing for parents that struggle to engage with FAR services *and* have been assessed as presenting with elevated risk for child maltreatment is problematic, and for some children will have devastating consequences.

Further, there were no referrals to DCF for suspected abuse or neglect made by the mother's mental health provider (when she stopped coming despite significant mental health and substance abuse concerns and the presence of young children in the home); by the medical provider (when mother reported being in crisis and having difficult functioning during the day, yet declining crisis evaluation and support); by Birth to Three when the mother repeatedly did not follow up with service referrals for her children; or by the pediatrician. Not all providers had information necessarily rising to the level of suspected abuse or neglect, but the fact that none of these providers contacted DCF is concerning.

6. <u>Inadequate Quality Assurance Framework To Support Effective Assessment and Case Planning</u>

Reviewers identified several deficiencies in supervision and quality assurance practices during the investigation of Londyn's death.

- DCF's supervisory chain of command failed to identify the weaknesses and deficiencies in the case practice and correct these mistakes, including the lack of information on the mother's mental health treatment needs and service history and the failure to seek out-of-state child welfare records. These deficiencies persisted despite the children intersecting with DCF *five times* in the nineteen months prior to Londyn's death.
- DCF does not yet have a robust system for quantitative and qualitative assessment of its intake, screening and assessment process.
- DCF does not yet have a reliable quality assurance framework for its utilization of the SDM risk and safety tools.

- DCF will need to incorporate wide-spread case sampling, peer review or multi-disciplinary case review at the area office/regional level to assist with continuous quality improvement efforts regarding case assessment and practice.
- DCF has not yet incorporated a system-wide qualitative review of FAR assignments and FAR-related individual case practice.

It is important to note that during the course of this investigation, DCF reported to OCA and the Child Fatality Review Panel that it is embarking on multiple steps to address quality assurance gaps and to ensure that there is an effective framework for evaluating case practice, including risk assessment. Several of these goals and action steps are summarized below.

SECTION II: RECOMMENDATIONS

Many of authors' recommendations outlined in this section are drawn from OCA's 2014 public report regarding the preventable deaths of infants and toddlers in Connecticut, found on OCA's website: http://www.ct.gov/oca/site/default.asp.

DCF reported to OCA and the Child Fatality Review Panel that in response to Londyn's death it has taken the following internal action steps:

- changes in the leadership of that DCF Region;
- enhancing the use of the standard SDM Screening and Response Priority Tools and reinforcing critical thinking by DCF staff;
- increased collaboration with collaterals;
- creation of practice guidance;
- updating the practice guidance for very young children;
- drafting infant and toddler protocols;
- creation of another tool to look at investigation and FAR practices;
- improvement of assessments of family dynamics and risk as an ongoing part of several Communities of Practice;[43]
- survey of the child welfare field and determination that SDM remains the best tool available;
- creation of an SDM workgroup to refine the use of SDM;
- looking at FAR track assignments at Careline and working with the DCF Office of Research and Evaluation to refine that [Quality Assurance] process; and
- development of a QA process regarding non-accepted reports (the resulting tool will look at factors such as young children ages 0-5, and indicators of substance use, mental health, interpersonal violence, prior DCF history and caregiver's past involvement in DCF as a child).[44]

[43] Communities of Practice are internal groups at DCF that examine various aspects of DCF's work with children and families.
[44] This list is taken from an October 19, 2015 letter from DCF leadership to the Office of the Child Advocate.

DCF is creating a new infant-toddler framework and will develop a quality assurance protocol to assist with implementation. DCF is also developing a new predictive analytics framework for responding to concerns of abuse and neglect. DCF has reported that it is working with the Children's Research Center (a division of the National Council on Crime & Delinquency) to review its risk and safety assessment tools and will work to ensure reliable and high quality assessment practices. DCF anticipates developing a quality assurance framework specifically for the SDM assessment tools.
The recommendations outlined above are all positive and the OCA and CFRP look forward to learning additional information about the implementation of these improvements. OCA offers the following additional recommendations to the extent that they are not clearly encompassed by DCF's own internal action plan.

Ensure Reliable Risk and Safety Assessments

- Child welfare assessments must include information from all relevant collateral sources, including education, pediatric health care providers and mental health professionals, and there must be a quality assurance framework to ensure adherence to these requirements. No case (at a minimum, no case assessed via SDM as having elevated risks) should be closed without appropriate fact-finding and no assignment to FAR should be completed without this information.[45] If barriers to obtaining required information exists, a DCF legal consult should be undertaken to determine appropriate next steps.
- Assessments and screens (including those done at the DCF Careline) should give due consideration to the family's history of reported maltreatment concerns consistent with ongoing studies demonstrating that these elements are *significant predictors* of child abuse and critical injury.
- Ensure that both DCF and the Community Partner Agency conduct ongoing risk and safety assessments as part of case management. Currently, the contract requirements for the Community Partner Agencies anticipates that the CPA will develop a "Plan of Care" for the family "following a comprehensive assessment of the family's strengths, resources, supports and needs as identified by the family and their support network."[46] This requirement does not clearly require the CPA to conduct ongoing risk and safety assessments.

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[45] See *Minnesota Governor's Taskforce on the Protection of Children Final Report and Recommendations, March 2015* at 16-17 ("Ensure fact-finding occurs in all child protection responses… [while high risk cases must be handled with traditional CPS response and "clearly low risk" cases may be assigned for differential response, "all other cases, which include those with moderate risk and those which are difficult to assign without additional information … require fact-finding before track assignment can be made. [The child welfare agency shall] provide guidance on necessary fact finding inclusive of collateral contacts and face-to-face interviews with child subjects and parents or caregivers"); see also Pioneer Institute Report on Massachusetts Differential Response System, found on the web at: http://pioneerinstitute.org/better_government/study-overhauling-two-tiered-case-intake-system-is-key-to-dcf-reform/ at 19 ("[A] number of studies point out that cases diverted to an alternative track often end up being moderate-to high-risk cases. To eliminate re-occurrence of this issue in Massachusetts DCF cases, the agency should strengthen its critera for intake assignments by adding areas to check before a track assignment decision is made… DCF should seek information from collateral sources before a case intake decision is made… If sufficient information is not immediately available, track assignment should be postponed until *more facts can be determined."*) (emphasis added.)
[46] *Scope of Services, Contract Performance, Budget, Reports and Other Program-Specific Provisions* for the Community Support for Families Program, at 5.

- Implement rigorous quality assurance for utilization of the SDM safety and risk assessments, inclusive of *systematic case sampling and qualititative and quantitative review* to determine the reliability of the assessments of "low" "moderate and "high risk" families.
- Moderate risk families that fail to engage with the FAR program may need to be re-routed back to DCF for follow up and possible child protective services supervision.[47] Current FAR guidelines provide that "on occasion, families who are moderate or high risk levels with current risk factors within the last 12 months may be referred to the [CPA] for services if the family *prefers* to be engaged by the [CPA] rather than remain involved with [DCF]."[48] However, while voluntary engagement between the family and a support agency may be beneficial, where the risk for child maltreatment is elevated, the family's preference and even the potential benefits of the volitional program cannot trump the child's need for protection and supervision by DCF.
- Ensure front line staff working with families are appropriately experienced and credentialed. For example, the Child Welfare League of America recommends that case workers be *licensed social workers* at the time of hire or within 6 months of hire,[49] and that all supervisors, managers, and directors have clinical, professional licenses in social work and related fields.[50] Alternatives to licensing requirements for hiring should also be available that credit individuals who have demonstrated skills and experience with family assessments, case planning and care coordination.[51]
- Review and revise, where necessary, the SDM tool Connecticut uses to ensure inclusion of all pertinent risk and safety factors.

Develop High Risk Infant and Toddler Protocols

- Develop a practice model specific for infants and toddlers that reflects these children's risk for critical and fatal child abuse injury.[52]

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[47] See Pioneer Institute Report, *supra* n. 40 at 19 ("In cases when families are assigned to the assessment track and refuse voluntary services, [the child welfare agency] should be notified for follow up review to assess whether families that refuse services should be moved to the [Child Protective Services] traditional track…. Hawaii has a system in place whereby cases with families that elect not to accept recommended services are 'routed back to DCF for a possible investigation and/or court ordered service plan.' Massachusetts DCF should adopt a similar practice.") (citing Piper, Kathryn. Testimony to the House Human Services Committee, Vermont House of Representatives, 29 January2014. Available at: http://legislature.vermont.gov/assets/Documents/2014/WorkGroups/House%20Human%20Services/Child%20Protection/W~Kate%20Piper~Testimony~1-29-2014.pdf).

[48] *Scope of Services, Contract Performance, Budget, Reports and Other Program-Specific Provisions* for the Community Support for Families Program, at 2.

[49] Child Welfare League of America*, Quality Improvement Report for Massachusetts Governor Deval Patrick (May 22, 2014)* at 46.

[50] Id.

[51] The social worker job specification is developed by the Department of Administrative Services. DCF is working with DAS to develop a "social worker 2" level includes the contents of this recommendation. Funding for these positions remains a matter of budgetary policy.

[52] Massachusetts recently proposed a new protocol requiring DCF to "screen in" at the hotline any report regarding a child five years of age or younger and where there are young parents or a parent of any age with a history of substance abuse, domestic violence, or mental health challenges.

- Ensure the risk and safety assessment for infant-toddler cases includes a multi-disciplinary case evaluation process with input from all necessary professionals: the social work supervisory staff, DCF's in-house clinical consulting team, the DCF in-house legal staff, and the child's pediatrician and other relevant stakeholders working with the family.
- The infant-toddler practice model should include a High Risk Infant Policy with heightened requirements for case supervision, team case planning, visitation contacts, home-based service delivery, and mandatory triggers for legal consults and court filings—such as lack of engagement by the family with DCF or a refusal to permit access to the child.[53]
- DCF's infant toddler practice guidelines should include input from developmental pediatricians, service providers, law enforcement and early childhood experts.
- Public reporting of child welfare and safety outcomes for all infants and toddlers who are subject to a DCF investigation or are assigned to the FAR track. Reports should include how many children are subject to repeat reports of abuse, neglect or critical injury during and following receipt of assessment or case management services by DCF or its contracted Community Partner Agencies.
- DCF must have support to lower caseloads for workers with in-home cases to ensure that caseworkers have time to do frequent visits and assessment with families—a key protective factor identified by both OCA and DCF. A recent report in Minnesota recommends this the state child welfare agency permit a *cap of* 10 case management cases per worker.[54]
- DCF must have support to ensure supervisors are responsible for a maximum of *5* caseworkers and the children they are working with.

Ensure Reliability of Careline Screening and Response

- Strengthen screening protocols to ensure appropriate weight is given to a family or caregiver's history of child maltreatment as part of the assessment and disposition of the call.
- Develop a multi-disciplinary team to consult on DCF Careline protocols. The group should include law enforcement, education and medical professionals and meet regularly with DCF to review how well the concerns of abuse and neglect are being addressed and update agency guidance. Similar recommendations have recently been made in Minnesota and Indiana.
- Revise Careline protocols to ensure that allegations of abuse and neglect involving children under age 2 are screened in rather than screened out, and that allegations involving a seriously impaired caregiver or physical abuse are responded to within 4 hours.
- Mandate legal consult where families have come back at least twice in a 12 month period or have a history of non-engagement.
- Ensure rigorous quality assurance that consists of multidisciplinary call and record review to assess quality and reliability of Careline practices.

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[53] DCF has had a high-risk newborn policy on the books for many years, but it is an outdated policy that limits mandates regarding heightened supervision to four weeks from the infant's discharge from a hospital. Previous OCA investigations indicate that this high risk newborn policy is virtually never referenced or utilized.

[54] MN taskforce report at 30? http://safepassagemn.com/governors-task-force-child-protection-work-group-meetings-february-27th-2015/

Improve Information-Sharing

- Legislatively create timelines to compel third parties' response to DCF's requests for information from community provider agencies (medical, mental health, and education).
- Legally require that all relevant out-of-state child welfare records be sought during child welfare investigations or FAR assessments. This is the second child fatality that OCA has reviewed in the last year where out-of-state child welfare records were either not sought or not obtained during the critical assessment stage.

State Strategies: Strategic Assessment and Service Delivery

Increasingly, national experts in child maltreatment fatality prevention articulate the need for a cross-agency, multi-disciplinary approach. Consistent with this vision, OCA offers the following recommendations:

- Multi-agency Strategic Plan for Fatality Prevention: The state must continue to develop an inter-agency framework for fatality and critical injury prevention for infants and toddlers. The framework must contemplate information sharing and strategic funding and supports for at-risk and vulnerable children. Strong partnership between health care, early childhood service continuum, law enforcement, Medicaid, and child welfare must continue to be supported. The state's inter-agency partnership to prevent "unsafe sleep"-related infant deaths is a great example of a promising collective approach to fatality prevention.
- Invest in two-generation service delivery. Increase funding streams and strengthen capacity to deliver intensive, therapeutic parent-child interventions that can work with at-risk and high-risk caregivers (struggling with substance abuse, depression, interpersonal violence) and their children. The state's goal must be to eliminate wait lists for children and parents involved in the child protection system. DCF and the Office of Early Childhood fund several important two-generational programs for parents with young children, but gaps remain in the state's capacity to deliver "two-gen" services for all of the children that need them.
- Increased screening for young children. Any child who is the victim of suspected maltreatment should be screened or assessed for trauma and developmental red flags and referred for appropriate services. Multiple screening initiatives are underway in Connecticut, and DCF is working to ensure that more maltreated infants and toddlers are assessed and referred for early intervention services; yet gaps in screening and access to critical early intervention services remain.

RECOMMENDATIONS FOR FURTHER EVALUATION OF THE STATE'S FAMILY ASSESSMENT RESPONSE SYSTEM

The review of Londyn's death necessarily led to an examination of how a family presenting with persistent child welfare history and risk factors for ongoing child maltreatment was assigned to an alternative track (FAR) intended for lower risk caregivers. Authors sought to understand whether similarly situated families, i.e. families presenting with chronic, repeat or persistent child welfare

history related to substance abuse or untreated mental health issues have also been assigned to the FAR track, and if so, what the outcomes have been for those families.

Authors of this report addressed this issue through multiple discussions with the Child Fatality Review Panel, a review of data regarding FAR presented by DCF and the University of Connecticut School of Social Work Performance Improvement Center, and multiple discussions with DCF personnel.

Data collected to date by DCF and UConn has included (but not been limited to) attention to the repeat maltreatment outcomes for children living in families assigned to FAR. There is not yet an evaluation of a comparison or control group to analyze the relative effectiveness of FAR versus traditional DCF case management as a framework to prevent repeat maltreatment.

Authors are not equipped at this time to draw conclusions about the efficacy of the Connecticut FAR model. However, the authors' investigation into this particular fatality has suggested multiple areas for further research and evaluation by the state child welfare agency and its partners.

Relevant data points regarding outcomes for families assigned to the FAR track to date include:

a. Over 40% of all accepted reports of abuse or neglect to the DCF Careline are now tracked to FAR;
b. Approximately 30% of families assigned to the FAR track have been re-reported to DCF for suspected abuse or neglect since program inception (2012). A re-report and a subsequent *legal substantiation* of maltreatment are not the same.[55]
c. Of the 30% of families that were re-reported to DCF, those with pior DCF history were more likely to be re-reported to DCF than families that did not have DCF history (38% vs. 19% respectively).
d. According to DCF's most recent FAR report, "factors associated with having a negative outcome (i.e., shorter time to subsequent child welfare report) [include] more prior [DCF] reports, having young children."

Londyn's family falls into the cohort of families that DCF has thus far found are the most likely to have a negative outcome following assignment to FAR: multiple prior DCF reports and children under age three in the home. Though authors of this report reviewed the facts leading to Londyn's death and the data regarding FAR, authors did not have comprehensive data regarding the quality and reliability of intake, assessment and case assignment practices, or benchmarks for performance relevant to a further anlysis of the FAR framework. Accordingly, authors urge the state to ensure that ongoing and future evaluations of FAR further examine the following:

[55] Families that are re-reported face a range of responses from dismissal of the report, a formal investigation into abuse or neglect, or a re-referral to FAR. Families that are referred to FAR will not be subject to a finding of substantiated maltreatment. Families that are referred to FAR *multiple times* will also now be reflected in data regarding repeated *substantiated maltreatment*.

- Outcomes for families that decline services, drop out of services or struggle to engage with the FAR provider;
- The most effective service interventions for families assigned to the FAR track and those tied to the most positive outcomes;
- Through case sampling and multi-disciplinary case review, the quality of intake screening and case assessment practices, including evaluation of the reliability of DCF risk and safety determinations;
- An examination of how cases assessed as *moderate risk* are handled from the assessment stage through disposition and outcomes. Such an examination should review the reliability of the risk assessment and the appropriateness of dispositions, including case closures and assignment to CPS or FAR;
- Through case sampling and multidisciplinary review, the quality of engagement, assessment and service delivery by the DCF-contracted Community Partner Agencies;
- Examination of the ongoing guidance, training and technical assistance to support the work of the Community Partner Agencies with the referred families;

Additionally, authors recommend the following:

- DCF's quality assurance framework should employ, wherever possible, validated tools to assess the quality of practices related to assessment, care coordination, cultural competence, service delivery, family engagement and discharge planning for families served by child protective services *and* the FAR-contracted providers. Reviews should also qualitatively assess cases where families refused services, failed to successfully engage with the community provider, or were assessed by DCF as needing "no further agency involvement."
- Review of FAR as a child maltreatment prevention framework must be evaluated pursuant to clear performance benchmarks for expected or hoped-for rates of re-reports to DCF and subsequent substantiated findings of abuse and neglect. A control or comparison group of families served by DCF should be considered in order to assess the differences in the rate of return to DCF attention.
- Examine the language that defines which families will benefit from the FAR intervention and be likely to engage and follow through with services for themselves and their children. It is the authors' assumption that FAR is not designed to be the primary case management and care planning process for complex families with *unresolved* histories of substance abuse, mental illness, domestic violence, and chronic child welfare involvement. Evaluation of FAR outcomes must include a close analysis of outcomes associated with families who have prior DCF history, chronic DCF history, young children and elevated risk assessment scores.[56]

[56] DCF FAR guidelines provide that families who "are at moderate or high risk levels with current risk factors within 12 months *may* be referred to the Community Partner Agency [FAR provider] for services *if the family*

- Develop specific policies regarding handling of repeat FAR assignments that includes analysis of the *quality* of previous FAR interventions and the family's record of successful or unsuccessful engagement, and demonstrated benefit from the intervention. No family should be re-referred to FAR without documenting this assessment.
- The state should develop a multi-disciplinary taskforce consisting of representatives from key mandated reporter groups, family representatives and child safety experts to advise the legislature and DCF regarding the ongoing implementation of a two-track child welfare system.

APPENDIX 1: Explanatory Note on Child Protective Services Practices

To better understand the issues and recommendations discussed in this report, authors include the following brief primer on key child welfare practices and protocols.

Calls of Abuse or Neglect of a Child

Allegations of suspected abuse or neglect of a child are called into the DCF Careline (formerly known as "Hotline.") Calls are either: 1) **accepted for further investigation or Family Assessment Response** because a determination is made that the legal threshold for suspected abuse or neglect has been met; or 2) **"non-accepted"** thereby no investigation is undertaken. Depending on the degree of severity of allegations and risk level in home, response time for accepted calls are coded as "Same Day," within 24 hours or within 72 hours.

Mandated Reporters

Each state has a list of professionals and service providers that are obligated as a matter of law to report suspicions of abuse or neglect to the child welfare agency (e.g., law enforcement, school personnel, pediatricians, dentists, mental health providers, and others). In addition, any individual who suspects a child is a victim of abuse or neglect may call the concern in to DCF. State law protects callers who reasonably suspect a child is abused or neglected from retaliation. The call system at DCF is now known as "The Careline."

DCF's Two-Track System for Responding to Calls that Allege Suspected Abuse or Neglect: Differential Response

In March of 2012, Connecticut implemented a two-track system for responding to calls of suspected abuse or neglect of a child. Cases that are deemed "lower risk" may be coded as requiring a 72-hour response by DCF and are tracked to the local DCF office for a **Family Assessment**, as long as no "rule outs" prevent the family's assignment to the FAR track. Calls that raise higher risk concerns are coded for more immediate response - within 24 hours - and are tracked to the local DCF office for an **Investigation response.** Families assigned to both tracks receive a safety and risk assessment by

prefers to be engaged by the [CPA] rather than remain involed with the Department." See *Scope of Services, Contract Performance, Budget, Reports and Other Program-Specific Provisions* for the Community Support for Families Program, pg. 2.

DCF. DCF staff have up to 45 days to determine next steps to address the abuse/neglect report. The DCF staff can switch the cases track from FAR to Investigations if initial or further assessment deems such a change is necessary to protect the child. This framework is in use in several states around the country, with models for implementation varying.

Rule-outs for FAR *in Connecticut* include:

a. Any report on an open protective service case in CT or another state;
b. Congregate care, foster care or persons entrusted;
c. Prior or current child fatality due to abuse and/or neglect with surviving siblings in the home
d. Current report with allegations of sexual abuse against a parent, guardian or person given access;
e. Previous adjudication of Abuse or Neglect in Superior Court for Juvenile Matters in Connecticut or another state[57]

Track One: Investigations/Traditional Child Protective Services Response

Higher risk cases are referred to the local DCF office's for an investigation. The 45 day investigation will result in an administrative finding of Substantiation or Unsubstantiation of Abuse or Neglect of a child against an identified perpetrator. DCF may also take any of the following actions: 1) close the case after concluding the investigation, if no safety concerns are identified that warrant the family's continued involvement with DCF; 2) open a family's case for ongoing child protective services supervision; 3) file a neglect petition with a local juvenile court; or 4) remove the child from the care of the parent (pending court approval) if the child is in imminent risk of bodily harm. The court can compel family participation in a range of rehabilitative services, and DCF may take progressive steps to protect the safety of a child up to and including foster care, termination of parental rights and adoption. A child who is the subject of a court petition alleging abuse or neglect is provided a lawyer to advocate for the child's needs and wishes.

Track Two: Family Assessment Response

Family Assessment Response is part of Connecticut's new two-track framework for Differential Response to child abuse or neglect concerns. Families assigned to FAR also receive a 45-day assessment by the local DCF office, the same as a family referred for an investigation. The FAR track will seek to serve lower risk families through voluntary, community-based case management and services.

How does Family Assessment Response/DRS Work in Connecticut?

As stated above, all allegations to the DCF Careline that rise to the level of suspected abuse or neglect must be accepted for further action. The calls go through a screening process to determine the severity of the report.

[57] States make different choices about how to use the Alternative Track. Some states have been very conservative regarding whether a family with prior child welfare history can be referred to an Alternative Track. Other states have permitted broader use of the Alternative Track framework.

Family Assessment Response describes the non-investigatory pathway where assessment is conducted by DCF but no substantiation of child abuse or neglect is made. Any report that is ultimately determined not appropriate for continuation on the FAR track will be opened for investigation, traditional DCF case management and possible court involvement.

If the family's case continues on the FAR track, the DCF office may refer the family to a local service agency, known as a community partner agency (CPA). Case management support is not provided by DCF, but instead will be facilitated by the CPA. The family's participation with the CPA is voluntary. DCF closes the family's case after the referral to the CPA is complete. If the family chooses to continue with the CPA then the family will be served for a period of approximately 4 months,[58] ideally having been connected to the supports that they need.

A family's decision to refuse referral to or engagement with the CPA is <u>not grounds</u> for returning the family to DCF's supervision.

<u>Benefits and Questions about Differential Response Across the Country</u>

According to a November 2014 report by the federal government's Children's Bureau (a division of the Department of Health and Human Services), evaluations of the Differential Response System have been undertaken in at least 20 states and while some outcomes have been positive, the Children's Bureau states that **"overall results have been mixed."**[59] Studies confirm increased family and caseworker satisfaction, among other positive results. Several studies show either a lower or equivalent likelihood of repeat maltreatment for families served by DRS as compared with traditional child welfare response.[60] However, recent studies in some states have "identified problems with fidelity and inconsistent practices."[61] A recent study in Illinois showed an *increase* in the risk for repeat child maltreatment in families served by the state's DRS program. Illinois has since retreated from its investment in a two-track system. A 2015 taskforce report in Minnesota, issued after the murder of a 4 year old boy assigned to the child welfare agency's low-risk track, cautioned that any system, single or multi-track, necessarily relies on rigorous and high quality assessment as well as robust quality assurance and reporting.[62] Most recently, Massachusetts eliminated its two-track system after investigative journalists reported that 10 children who died of abuse and neglect between 2009 and 2013 had been assigned to the "alternative track."[63]

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[58] Four months is the average duration of service; services may extend longer.

[59] Differential Response to Reports of Child Abuse and Neglect. Child Information Gateway Available (at 9) online at https://www.childwelfare.gov/pubs/issue_briefs/differential_response/

[60] Id. "Early studies revealed that children in [Differential Response] cases were less likely or as likely as children in [Investigative Response] cases to be the subject of a subsequent report or investigation (Center for Child and Family Policy, 2009; Loman et al., 2010; Shusterman, Hollinshead, Fluke, & Yuan, 2005; Siegel et al., 2010; Siegel & Loman, 2006)."

[61] Id. pg. 9

[62] Cite.

[63] http://necir.org/2015/11/17/gov-baker-eliminates-controversial-dcf-two-tier-system-for-at-risk-children/

Recent reports on DRS emphasize that states must clarify which families are truly "low risk" for child maltreatment. Low risk is not the same as no risk.[64]

Descriptions of DRS across the country note that certain allegations should be automatically "ruled out" for DRS—e.g., physical or sexual abuse. Other allegations may be deemed "lower risk," e.g., educational neglect or subsistence concerns and therefore appropriate for alternative response. However, there is substantial room for error in these determinations and many cases and allegations may fall somewhere in the middle of low and high risk. A report to a child welfare agency hotline may describe a potentially lower risk case of physical neglect (e.g., excessive truancy, toddler with inadequate supervision), but other facts or history available to the agency may or will (if discerned) confirm the presence of significant risk factors for maltreatment such as untreated mental health or substance abuse issues and a history of abuse/neglect concerns.[65] States' various modifications to DRS and associated individual practice changes have not all been individually reviewed according to one recent report "present a confounding factor for evaluation."[66]

APPENDIX TWO: INFANT AND TODDLER DEATHS 2014.

Deaths of Infants and Toddlers 2014

In 2014, there were 36 infant and toddler deaths reported to the OCA by the Office of the Chief Medical Examiner (OCME) whose deaths were attributed to intentional and unintentional injuries.

- 21 were classified as Undetermined (often associated with unsafe sleep practices)
- 8 were classified as Homicide (Londyn and 7 other infants and toddlers)
- 7 were classified as Accident

Deaths of Infants and Toddlers Whose Families had A History of Maltreatment Concerns

Of these 36 unexpected and untimely deaths of infants and toddlers outlined above, 19 children lived in families that had a documented history of maltreatment concerns by an entrusted caregiver.

- 10 children had open cases with DCF at the time of death.
- 3 children's families had DCF cases that had been closed within 6 months of the death.
- 1 child's family had a case closed between 6-12 months prior to the death, and
- 5 additional children lived in families that had prior DCF involvement with other children in the family.[67]

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[64] John Fluke, et al. Differential Response, 16th Annual Child Welfare Waiver Demonstration Projects Meeting July 2014.

[65] Connecticut DCF returns about 12% of cases initially assigned to FAR back to investigations.

[66] *Id.* Presentation, July 29, 2014.

[67] 10 open cases include: 6 Undetermined Deaths; 2 homicides (perpetrators were the babysitter and the father, respectively); 2 accidental deaths (perpetrators were the parents; both families had documented issues with substance abuse). Three closed cases/6 months include: 1 Undetermined Death, 2 Homicides (both perpetrators had substantial child welfare history); 1 case closed within 12 months, baby died in the bathtub with mother.

Not all of these deaths were deemed by DCF investigation to be the result of "maltreatment," and not all deaths are the result of poor DCF practice. Rather, the prior child welfare history is significant given the increasing research confirmation that such history is a significant risk factor for both unintentional and intentional death of an infant or toddler. Studies in the Journal of Child Maltreatment (2011) and the Journal of Pediatrics (2014) found that a history of child maltreatment concerns is a significant predictor of Sudden Unexplained Infant Death and death from injury in children under age 5. Specifically, researchers found that "after adjusting for baseline risk factors, the rate of Sudden Infant Death was more than 3 times as great among infants reported for possible maltreatment,"[68] and that children with a prior allegation of maltreatment died from intentional injuries at a rate that was 5.9 times greater than unreported children and died from unintentional injuries at twice the rate of unreported children.[69] Authors in the latter study concluded that a "prior allegation to [Child Protective Services] proved to be the strongest independent risk factor for injury mortality before the age of five."[70]

A Closer Look at All Infant-Toddler Homicides, 2014

While this report primarily focuses on the systems that interacted with Londyn and her family, Londyn's homicide was one of eight infant and toddler homicides in Connecticut in 2014.

- Athiyan was 19 months old; he died as a result of fatal child abuse/abusive head trauma; his babysitter was convicted of killing him, and his parents were charged for their failure to protect him.
- Ryder was 2 years 9 months old; he died from choking on food while being left alone in his home along with an infant. Ryder's father's girlfriend has been convicted in his death.
- Adore was 2 months old; she died from blunt force trauma and her father was convicted of killing her and sentenced to 15 years in prison.
- Benjamin was 16 months old; he died from hyperthermia, and his father was convicted of negligent homicide for leaving Benjamin in the car all day.
- Zaniyah was 14 months old when she died from a stab wound; her uncle pled guilty to charges related to her death.
- Baby Boy S. was a newborn who was left in a garbage bag; his mother has been convicted in connection with his death.
- Jaleah was 21 days old; she did as a result of fatal child abuse; the infant's babysitter was convicted in this death and sentenced to eight years in prison.

[68] Putman-Hornstein, Schneidman, J., et al (Jan. 2014), "A Prospective Study of Sudden Unexpected Infant Death after Reported Maltreatment," Journal of Pediatrics Vol. 164, 1 (pp. 142-148).
[69] Putnam-Hornstein, et al. (June 2011), "Report of Maltreatment as a Risk Factor for Injury Death: A Prospective Birth Cohort Study," Journal of Child Maltreatment, 16, 3 (pp. 163-174).
[70] Id.